ADULT CARE HOM. CORRECTIVE ACTION REPORT

MAY 26 2011

I. Facility: Tillery Chase Adult Care Home		Facility License #:HAL-062-004	County: Montgomery
Facility Address:110 Roosevelt Street Mt. Gilead NC, 27306 PO Box 747 Mt. Gilead NC, 27306	Date(s) of Visit(s): 12-21-2011, 1-19-2011, 1-31-2011, 2-1-2011,2-8-2011 and 2-15-2011	Time(s) of Visit(s):	
Administrator/Authorized Representative: Cindy Majors Regional Vice President; Sherry Cotton Director			

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II. Purpose of Visit:	Complaint Investigation

To The Provider: The following violations are considered TYPE B VIOLATIONS. Included in this CAR is the directed date to achieve compliance (column d). Failure to meet compliance after that date could result in a civil penalty in an amount up to $400.00 for each day that the facility remains out of compliance.

III a. Rule Violated and Reference	b. Findings that confirmed violation	c. Facility plans to correct/prevent	d. Date plan to be completed
10A NCAC 13F .1004 Medication Administration (a) an adult care home shall assure that the preparation and administration of medications, prescription and non prescription, and treatment by staff are in accordance with. (1) orders by a licensed prescribing practitioner which are maintained in the residents record; and (2) rules in this section and the facilitiy's policies and procedures ***This rule is not met as evidenced by:*** ***Based on observations, record reviews, staff and resident interviews, the facility failed to provide proper medication administration for 1 of 5 residents.*** ***This Is a Type B Violation.***	The findings are: The census on 1-31-2011 was 58 residents. Review of FL-2, dated 1-19-11, for resident #1 revealed diagnoses of cerebral degeneration, intestinal impaction, G.I hemorrhage, Change in mental status, History of urinary tract infection, pneumonia, dehydration and diverticulitis. Current medication order per FL2 included Morphine Sulfate 20mg/ml give 5-10 mg po/sl/q4hrs prn. Record review further revealed that resident #1 was given 5cc of morphine sulfate from a medication dispensing cup instead of a 10 mg oral syringe. Based on record review and observation of resident on 1-31-2011 #1 it was determined the resident was unable to be interviewed. The resident would be unable to provide reliable information. 1-31-201110:45am confidential interview with staff	Records will be reviewed @ 10 per week will be done by Consultant or RCC and director or director assistant. using Medication Monitoring form. Med Tech terminated on 1-18-11 Med. techs inserviced 2-24-11	3-29-11 CW

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	member revealed that resident #1 was given 5cc of morphine sulfate from a dispensing cup instead of an oral syringe. Staff member reported that the third shift med tech could not find the oral syringes on the medication cart and used an oral med cup instead. Staff member reported that resident was given 10 times the amount of morphine as prescribed. Staff revealed that the third shift med tech called 911 and Hospice after realizing the error. Staff reported that EMS arrived shortly after 2:30 am and transported the resident to Stanly Memorial Hospital. Further interview with staff member revealed that the third shift med tech had been suspended pending the outcome of the investigation. 1-31-2011 11:00 am confidential interview with staff member revealed that on 1-18-2011the third shift med tech called them to report a medication error. Interview with staff further revealed that resident #1 was given the wrong dosage of morphine sulfate and was being sent to the hospital. 1-31-2011 11:15am confidential interview with staff member revealed that an internal investigation conducted by the facility has revealed that the third shift med tech administered the morphine sulfate to resident #1 using the incorrect delivery method. Staff member revealed that the third shift med tech gave the resident 10 times the amount of Morphine Sulfate as prescribed. Staff reported that the third shift med tech had been suspended without pay pending the result of the facility's internal investigation. Adult Home Specialist was given a copy of a verbal counseling verification signed by the med tech. Staff member admitted to making the medication error and signed the document. 2-9-2011 3:45am confidential interview with staff member revealed that on 1-18-2011 a resident was administered an incorrect amount of morphine sulfate. Staff member reported that they checked on the named resident after the roommate came to the		

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	medication cart and reported that the roommate was having trouble breathing. Staff reported checking on the resident and verifying the breathing difficulty and called the med tech to come to the room. Staff stated that the med tech administered the medication to the resident. Staff reported going to the resident's room approximately 1 hour later to check on resident only to find resident having a large amount of fluid coming from nose and mouth. Staff reported calling the med tech to the room. Staff reported the med tech instructed them to clean the residents face and stay with her while she called 911. Staff reported that EMS arrived at the facility and transported the resident to Stanly Memorial Hospital. 2-9-2011 4:00am confidential interview with resident revealed resident was present during the incident with named resident. Resident stated they noticed the resident lying in bed struggling for breath and went to the lobby and notified the staff on duty that the resident was having trouble breathing. Resident stated that a staff member checked on the resident and called another staff member to the room. Resident stated that the resident was given some medication at that time. Resident stated they kept an eye on the resident to make sure the resident was ok and noticed that the resident was coughing up a lot of stuff. Resident reported notifying staff and the staff coming to the room to check on the resident. Resident stated that the next thing they knew the ambulance was being called and one of the staff stayed with the resident until the ambulance arrived. Resident stated the resident was taken to the hospital. 2-17-201 8:20am confidential interview with staff revealed that there was a medication error on 1-18-2011. Staff reported a resident came to the med cart to tell them a resident was having trouble breathing. Staff reported sending another staff to check on the resident. Staff reported checking the MAR for the		

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	resident and attempting to administer morphine sulfate to the resident. Staff reported that the medication was to be administered sublingual with an oral syringe. Staff reported checking the med cart and not being able to find any oral syringes with which to administer the medication. Staff reported that normally the syringes would be located with the resident medication. Staff revealed not being able to find the oral syringe and used a med cup to dispense the medication. Staff reported it was not until the residents roommate notified them the resident was having more difficulty that she realized she had probably given the resident too much medication. Resident reported they called 911 and Hospice and then notified the on call staff for the facility. Staff reported EMS arrived very quickly within 20 minutes and the resident was transported to the hospital.	Inventory sheets will be used to take inventory on Mondays. On Tuesdays when stock comes in Lead Cook will check in food and will return inventory list to director Pattons will order food needed. Lead cook will inform Director assistant Director of any needed items. Petty cash will be used to purchase any needed items	3-29-11
10A NCAC 13F .0904 Nutrition and Food Service **(a) Food Procurement and Safety in Adult Care Homes:** (4) There shall be at least a three day supply of perishable food and a five day supply of non-perishable food in the facility based on the menus, for both regular and Therapeutic diets. ***This rule is not met as evidenced by:*** ***Based on observations, record reviews, staff and resident interviews, the facility failed to provide a three day supply of perishable and a 5 day supply of non perishable food based on the menus for both regular and therapeutic diets.*** **This is a Type B Violation.**	The Findings are: The census in the facility on 1-31-2011 was 58 Review of the facility's dietitian approved lunch menu for 1-31-11was 1 cup cheeseburger casserole, ½ cup beets, 1 dinner roll, ½ cup fruit cocktail and 1 cup coffee, tea, water. Review of the therapeutic diet menus (low fat/low cholesterol, renal, and no concentrated sweets revealed ½ cup cheeseburger casserole, ¼ cup beets, and ½ cup of unsweetened fruit cocktail was to be served to residents on these diets. Observations on 1-31-11 from 12:00 pm to 12:45 pm revealed the facility staff present in the dining room were 2 personal care aides, 1 dietary aide and the cook. Observation revealed all residents were served the same food: 1 cup hamburger casserole,	Inventory will be taken daily. To insure ingredients for meals for t That day and the following day. Food supply will be restocked to meet guidelines. Director and RCC will observe.	

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	small ear of corn on the cob, toasted bread, and ½ cup of pineapple chunks. Water was not served or made available to every resident. There were no place settings observed on the tables. One resident on mechanical soft diet was served corn on the cob. Staff preparing thickened liquids for one resident was observed pouring the thickener into the liquid at the table without measuring the thickened liquid or waiting to check the thickened liquid. Observations of the facility's food supply on 1-31-11 at 11:05 am revealed no beets, no dinner rolls, and no fruit cocktail for service of the approved menu for the lunch meal of 1-31-11. Review of the substitution book revealed no substitutions listed in the book. Interview on 1-31-11 at 11:20 am with the cook revealed that she substituted corn on the cob for the tossed salad and pineapple chunks for the fruit cocktail. The cook said she did not realize the tossed salad and the corn on the cob did not have the same nutritional value. Sliced white bread was substituted for French bread. The cook stated that French bread was never available when listed on the menu. The cook said she did not place the food orders; the regional director ordered the food. The cook said she had to go to the local grocery store and buy hamburger meat so she could prepare the casserole for lunch. The cook revealed that there were several times that either she or the other cook had to go buy food in order to prepare the meals because there was not enough food in the facility to prepared the meals according to the menus. The cook also revealed that she was informed by the regional director to follow the menu prepared by the regional director, and not the menu signed by the dietician. Confidential interviews with (5) residents revealed 1-31-2011 12:20 pm confidential interview with resident revealed that on Saturday 1-29-2011 ham		

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	sandwiches and pork and beans were served for dinner and turkey sandwiches and pork and beans were served on Sunday 1-30-2011. Resident stated that the kitchen is locked up at night and staff did not have a key to get in. Resident stated that they cannot get water at night. Resident stated that there is never enough food for seconds at any meal. Resident stated that if they ask for seconds, the staff yell at them and tell them to go buy their own food if they are hungry 1-31-2011 12:30pm confidential interview with resident revealed that sandwiches were served to residents all weekend. Resident stated that there has been no sweet and low for two days. Resident stated that there is never enough food for seconds at most meals served. Resident stated that the kitchen staff told them that the facility buys what they want to buy and what is cheapest and not what is on the menu. 2-1-2011 Census for this day was 58. 2-1-2011 6:15 am review of dietician approved menu for breakfast meal for this date revealed 6 oz of orange juice, 1 each pancake w/ syrup, 1 each scrambled egg, 1 slice bacon, 1 tsp margarine, 1 cup water/coffee, 1cup milk and 1 tsp jelly. Review of the lunch menu for 2-1-2011 called for 3 oz sliced turkey, ½ cup yams, 1/cup green beans, 1 each dinner roll, 1/c fresh fruit, 1 tsp margarine and 1 cup beverage of choice. Review of dinner menu for 2-1-11 called for 3 oz smoked sausage, ½ cup stewed tomatoes, 1/2/cup fried squash, 1 each dinner roll, 1 pc/ ½ cup cake square, 1 tsp mustard, 1 cup milk and 1 cup beverage of choice. Review of food inventory on 2-1-11 at 6:30am revealed no bacon and 10 eggs for breakfast in the food inventory. There were no green beans, dinner rolls, or fresh fruit for lunch in the food inventory.		

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	There was no smoked sausage, no squash, no dinner rolls and no stewed tomatoes for dinner in the food inventory. 2-1-2011 6:55am interview with staff revealed sausage would be substituted for bacon for the breakfast meal. Staff revealed that other staff were sent to the local grocery store to buy eggs for breakfast. Fried squash was on the menu for dinner. Staff revealed no squash in inventory. Green beans were on the menu for lunch. Staff revealed no green beans in inventory. Dinner rolls were on the menu for lunch and dinner. Staff revealed there were none in inventory. Smoked Sausage was on the menu for dinner. Staff revealed there was none in inventory. Staff revealed that the food delivery would come around 1:00 pm that day. 2-1-2011 7:00 am Observation of breakfast meal revealed residents were served eggs, toast, orange juice, milk and coffee. Sausage was substituted for bacon and grits were substituted for pancakes. Residents were observed asking staff for seconds and were told there were no extra helpings. Several residents were observed eating food off of trays left by other residents after they had finished eating. 2-1-2011 7:30 am Confidential interview with resident. Resident stated that they did not eat breakfast. Resident stated that they could not eat that slop. Resident stated that they had money and were going to the local restaurant to get their own breakfast. 2-1-2011 8:00 am Confidential interview with resident. Resident stated that they did not get enough to eat. Resident stated that they were still hungry. Resident stated that they asked for more food but was told there was no more. Random record reviews of weights of residents for the past 3 months revealed weight losses for 7 residents. Weight losses ranged from 5 pound weight loss in 1 month to 11 pounds in 1 month.		

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	One resident had a weight loss of 5 pounds over a 3 month period and another resident had a weight loss of 12 pounds over a 3 month period.		
10A NCAC 13F Resident Rights 10A NCAC 13F Resident Rights An adult care home shall assure that the rights of all residents guaranteed under G.S. 131-D-21, Declaration of Residents' Rights, are maintained and may be exercised without hindrance. This rule is not met as evidenced by: Based on observations and interviews, the facility failed to assure residents residing in the facility received a reasonable response to his or her request for more food. This is a Type B violation	The findings are: The census on 1-31-2011 was 58. Observations on 1-31-11 from 12:00 pm to 12:45 pm revealed the facility staff present in the dining room were 2 personal care aides, 1 dietary aide and the cook. Observation revealed all residents were served the same food: 1 cup hamburger casserole, small ear of corn on the cob, toasted bread, and ½ cup of pineapple chunks. Water was not served or made available to every resident. Continued observations on 1-31-2011 at 12:30 am revealed on resident removing corn on the cob from a plate left at the table by another resident. The resident was observed eating the corn on the cob. Further observation of the lunch meal on 1-31-2011 between 12:00 pm and 12:45pm revealed three residents requesting seconds of the meal. One resident was observed walking to the kitchen door and requesting more food. The staff member told the resident there was no more food. The second resident sitting at a table asked a staff member for additional food and was told "there aint no more food" by the staff person. A third resident was observed asking a staff person for more of the casserole. The staff person responded to the residents by saying there was no more food. All residents had left the dining room by 12:45 pm. No resident received additional food. At the request of staff these interviews are confidential.	Kitchen Staff will remove residents plates as they finish their meal. Cooks instructed to prepare extra. for seconds. Assistant director, Director and RCA will observe. Staff inserviced on respectively responding to residents. AD, Dir., RCA will observe each dnr 3X for compliance	3-29- 2-29-11

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	One staff person revealed working 4 days per week. The staff reported that the residents are always asking for more food. The staff reported having to tell residents "no" everyday due to there not being enough food for additional helpings. The staff reported observing residents eating leftover food from other residents. The staff reported that the residents get angry and curse at the staff when there is no extra food. The staff reported that management knows about the complaints the residents have about there not being enough food but do nothing about it. A second staff person revealed that the reason there is never food for seconds is because there is barely enough food to cook for one serving. The staff person reported only being able to open two cans of any vegetable to serve. The staff person reported that two cans can only serve around 40 to 45 people and there are anywhere from 50 to 60 people in the facility on most days. The staff person reported feeling bad telling the resident there was no more food. The staff person reported that they knew the residents were hungry but they could not do anything about it. The staff person stated that food deliveries only come on Tuesdays. The staff person stated that there is usually extra food for the residents on the days immediately after a food delivery but by the end of the week and the weekend there is never enough food. A third staff person revealed residents complained every day about not getting enough food to eat. The staff person revealed that residents often complained about not getting enough to eat at resident council meetings. The staff person reported that residents routinely get upset with staff when they are told there is no more food for seconds. The staff person reported that one resident in particular often goes to the store and brings food back to the facility and asks the kitchen staff to cook it for them.		

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	1-31-2011 12:20 pm confidential interview with resident revealed the kitchen is locked up at night and staff did not have a key to get in. Resident stated that they cannot get water at night. Resident stated that there is never enough food for seconds at any meal. Resident stated that if they ask for seconds, the staff yell at them and tell them to go buy their own food if they are hungry 1-31-2011 12:30 pm confidential interview with resident revealed there has been no sweet and low for two days. Resident stated that there is never enough food for seconds at most meals served. Resident stated that the kitchen staff told them that the facility buys what they want to buy and what is cheapest and not what is on the menu. 2-1-2011 7:30 pm confidential interview with resident revealed that there is never enough food served at any meal. Resident reported going to the local grocery store to purchase food with his own money. Resident stated that he will ask the cook to prepare it for him so he can have something decent to eat. 2-1-2011 8:00 am Confidential interview with resident. Resident stated that they did not get enough to eat. Resident stated that they were still hungry. Resident stated that they asked for more food but was told there was no more. Resident reported that they were glad that someone had come to check on the situation. Resident reported being hungry at night after 8:00pm and there not being any food available to eat. 2-1-2011 8:30 am confidential interview with resident revealed the facility does not provide enough food. Resident reported the facility serves the same food over and over again. Resident reported that ham and turkey normally consist of		

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	processed ham or turkey with 3 slices rolled into on roll. Resident stated that they never get enough to eat. Resident reported asking other residents that are ambulatory to go to town to purchase food for them to keep in their room. Resident stated that residents that can walk can go up town to the Burger Shack or the Food King but they can not. Resident stated that dietary staff told her that the facility is not ordering food that is on the menu. Resident reported that dietary staff told them the facility is only ordering food once per week and it is never enough to last a whole week. Resident reported being served sandwiches on the weekend due to there not being food to cook. Resident stated they had quit asking for seconds because they knew it was a waste of time. 2-1-2011 9:15 am confidential interview with resident revealed the facility rarely has extra helpings at any meal. Resident reported that they often wait in the dining hall until other residents are finished to see if there is any leftover food. Resident reported that they are hungry especially at night. Resident reported that the kitchen is locked at night and the staff can not get into the kitchen to fix the residents anything to eat. Resident asked the adult home specialist to bring them a hamburger the next time they came to the facility. Resident asked the adult home specialist for two dollars to buy something out of the vending machines.		

IV. Signatures: Cindy Majors 3/9/11
Administrator — Date

Other Authorized Representative/Title — Date

Richard Evers 3/9/11
DSS Agency Representative/AHS — Date

V. Agency's Review: Disapproved ☑ By: Sw Richard Evers Due to Date: 3-23-11

Comments: Plans of correction not properly addressing issues found in CAR- Sent back to Fac. C.E. on 3/23/11 with request to provide further information for Corrective Plan of Action

VI. Agency's Review: Approved ☑ By: Richard Green Date: 4-1-11

Comments: Follow up Conducted 5-10-11 By AHS & Supervisor record reviews observations of meals staff & resident interviews were conducted, AHS found Corrective action plan to be in effect & followed By the facility, therefore the Type B 1 Rebate AHS will continue to monitor all sub areas

AHS Mailed to DFS: 5-18-11 Date Facility in compliance: 5-10-11 Failed Corrective Action: ____